CCC Plus Provider Webinars
Questions and Answers (Edited for clarity)

Nursing Facility/Adult Day Provider Webinar

Question	Answer
As our clients start receiving letters, will there be a website that lists the names of providers (PCP, specialists, hospitals, etc.) for each health plan? Also, with CCC, we could call in, but the client had to be next to us on the call. Is that still required?	You can search the enrollment website at cccplusva.com for information on participating doctors, specialists, hospitals, etc. for each health plan. You may also call the CCC Plus Helpline at 1-844-374-9159. You need to be an authorized representative if you call the Helpline to assist a member. Members can go on the website and make changes to their health plan as well. This is a new addition that your clients can use.
Is there a deadline to contract with health plans?	No; however, there is an advantage for those providers that contract early with a health plan. One is the health plans will operate with narrower networks than fee-for-service. The plans do not need to contract with any willing provider. Also, one of the criteria used in the CCC Plus intelligent assignment process considers member/provider relationships for certain LTSS providers participating with the health plans. For example, members receiving care through nursing facility, adult day, or (Tech Waiver) private duty nursing providers may be assigned to a health plan that is contracted with the member's nursing facility, adult day, tech waiver or private duty nursing provider.
Will the call centers be sufficiently staffed so wait times are not long?	Yes, Maximus has assured DMAS that they are adequately staffed and DMAS will monitor the call activity to ensure that is so. An alternative to calling the Help Line is the website, cccplusva.com. The MCO call centers are also fully operational and DMAS is monitoring the MCO's call center performance standards.
Are nursing facilities still restricted from completing a Uniform Assessment Instrument (UAI)?	Yes, nursing facilities are still restricted from completing a UAI. If the individual enters as a skilled or custodial patient and there is no UAI completed, health plans will accept the MDS (completed w/in the first 5 days of admission) and the DMAS 96 instead of the UAI. If the individual is changed to custodial status and then moved to the community, a UAI will need to be completed.
What if a Uniform Assessment Instrument (UAI) is not completed?	UAIs are completed by screening teams. It is more difficult when the person is in the hospital. If the nursing facility does not have the UAI, the health plans will accept MDS (completed w/in the first 5 days of admission) and the DMAS 96 in lieu of a UAI. The UAI process does not change in CCC Plus.

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Question	Answer
After enrollment in CCC Plus, the Pre-Admissions Screening (PAS) Team sends the PAS to the contractor. Will the contractor send a copy to the nursing facility or will the PAS Team send a copy to the nursing facility?	In CCC Plus, the PAS Team will send the PAS to the health plan. The health plan will then work with the member to choose a provider and then will send the PAS to the nursing facility chosen by the member or member's family.
With the 90 day transition plan, each provider will have to sign an agreement with the health plans in order to get reimbursed- even if you are not in contract to be a provider, correct?	Check with each individual health plan to get specific information on reimbursement as an out of network provider during the continuity of care period. DMAS will work with the health plans on this and will post information on the DMAS website.
Is there a chart available that compares each health plan's offerings?	Yes, a comparison chart is available on the CCC Plus website at cccplusva.com.
How does CCC Plus impact the annual Medicaid re-certification process?	The annual Medicaid re-certification determination will still occur as it does under Fee For Service (FFS). It is important that members submit completed paperwork as early as possible to avoid disruption of services. CCC Plus Care Coordinators can assist members with reminders to submit paperwork to avoid disruption.
When family members are responsible, they often allow the individual's Medicaid to lapse. How can we fix this?	That is a challenge that we recognize. We suggest that as you know that members have this issue that you work with the care coordinator at the health plan to see if they can provide assistance to the family.
Is there a portal with the dates of recertification for Medicaid members?	That is not available right now.
Please verify that the health plan will be responsible for submitting the PIRS DMAS-80 form for level and DMAS225 for eligibility information for CCC Plus members in a nursing facility.	Yes, that is the plan. We will release this process on the streamlining spreadsheet at a later date.
What happens once someone has full Medicaid eligibility?	They will be picked up by a CCC Plus health plan. This takes 45 - 60 days.
How often can a member change plans?	Members can change plans prior to the effective date, or within 90 days of their enrollment date. For Tidewater, members would have until the middle of December to change health plans. Members can change health plans 6 times. Once they get back to their original health plan, they cannot change again.

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Hospital/Medical Provider Webinar

Question	Answer
We understand there are going to be two health plans – CCC Plus and DSNP. How do we know which plan our patients will be enrolled in? What are the requirements in each plan for a person to be enrolled in?	There are actually 6 health plans participating in CCC Plus: Aetna Better Health of Virginia, Anthem Healthkeepers Plus, Magellan Complete Care of Virginia, Optima Health, United Healthcare, and Virginia Premier Health Plan. CCC Plus is a Medicaid benefit. Many CCC Plus members will also have Medicare coverage. CCC Plus plans will operate a companion DSNP plan. DSNP is a Medicare Advantage plan. Members will have the opportunity to align their coverage by choosing a plan that operates both as a CCC Plus and a DSNP plan. Under Medicare rules, the member has the ability to choose Medicare fee-for-service, a Medicare Advantage Plan, or a DSNP plan that is the same or different plan from their CCC Plus plan. You will be able to check on the assigned CCC Plus health plan (Medicaid) the same way you can verify today: ARS and Medicall. You should continue to verify Medicare coverage/health plan enrollment through Medicare.
Are patients being automatically enrolled in a health plan? Are they given a choice and how are they notified?	They are being given a choice. They receive an initial assignment letter to let them know which plan they have been assigned to. The letter also explains how they can keep the plan to whom they have been assigned or to change plans by visiting the CCCplusva.com website or calling the CCC Plus Helpline (Maximus). Along with the letter they will receive a comparison chart of all 6 health plans which includes information on each plan's enhanced benefits. They will also receive a brochure and invitations to town hall meetings. Individuals can also access information about the providers contracted with each health plan on the CCC Plus website or by calling the CCC Plus helpline. A confirmation notice will be sent as well, explaining that the Member has 90 days to change to a different health plan.
Will each of the CCC Plus information meetings that are listed on the website be covering different issues?	The meetings listed on the website are Town hall meetings and all will cover the same information.

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Question	Answer
If an individual enrolled in CCC Plus needs End Stage Renal Disease (ESRD) services and the local provider does not participate with the health plan, will the individual be allowed to change plans?	If they are already enrolled in CCC Plus and the health plan doesn't have a provider in network within the DMAS time and distance standards the health plan will have to authorize care out of network. The individual may be permitted to change health plans if the provider refuses to participate with the plan (on an out of network basis) and if there is not another provider within time and distance standards who can provide the needed care.
We performed an initial review of the cccplusva.com website to determine if our providers were listed properly. We found many errors in the listing. Are you working to correct these discrepancies?	Yes, we are working with Maximus and the health plans to correct the information on the website.
Will the Early Intervention (EI) providers that currently bill to the EI carve out be notified about these changes?	EI has been carved out of managed care in the past but it is included in CCC Plus. EI providers will need to bill the health plan for CCC Plus enrolled members. DMAS is working through DBHDS to educate the EI provider community, including the local lead agencies and other EI providers.
We bill weekly. Can we bill CCC Plus health plans weekly?	Please direct this question to the health plan. Be sure that this is in the negotiated contract between you and the health plan.
Is there an option for electronic billing?	Yes, all plans offer electronic billing options.
Will payers receive the historical claims information for members assigned to the plan? I'm assuming this information will be needed for the health plan to administer the 90 day continuity of care provisions.	Yes, DMAS will share medical transition files with the plans. Transition files include service authorization and historical claims information as well as active service authorization information that the health plan will honor during the continuity of care period. This information also helps the MCOs to identify who needs to be seen the quickest to minimize disruption of care.
What will be the future open enrollment dates for this population? Will it follow the same timeline as Medallion?	CCC Plus open enrollment (OE) will coincide with Medicare open enrollment, since over half of the population is also eligible for Medicare. The first CCC Plus OE is between October, November, and December of 2018, for a January 1, 2019 effective date.
We are aware that DMAS and DBHDS are working with Early Intervention, but in addition to this collaboration, are the providers notified via memo by DMAS of the change?	Yes, we have previously sent out memos and another memo is soon to be issued. You can access them on the DMAS web portal.

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Question	Answer
Will ePAS reflect these changes on July 1 or when the regions come on board?	The process for preadmission screenings does not change in CCC Plus. It remains the same.
Who should providers contact if they identify inaccurate data on the cccplusva.com provider directory (payer showing entity as in-network but we have no agreement)?	We are working with Maximus to correct a programming error that should fix many of the issues. However, it would be helpful if providers would print the pages that include inaccurate information and send it to us at cccplus@dmas.virginia.gov.
Is it correct that a patient can have Medicare through Aetna Better Health (DSNP) and then have Virginia Premier CCC Plus for their Medicaid?	That is correct.
How soon can we check eligibility in July to see who has been assigned to which health plan?	You can check beginning July19th.

Behavioral Health Provider Webinar

Question	Answer
For clarity, after January 1, 2018, will CMHRS services stay with Magellan or move to the CCC Plus payer?	CMHRS services will transition to CCC Plus as of 1/1/2018. Psychiatric Residential Facility services will remain with Magellan after 1/1/2018. FFS Medicaid and Medallion members will continue to receive CMHRS services through Magellan.
Will we be able to negotiate rates beyond the set DMAS rates with each health plan?	Rates can be negotiated with providers if it is mutually agreed upon. If an agreement is not reached, then the DMAS rate is the lowest possible rate that can be offered.
For carved out services currently covered for dual eligible individuals under CCC, under a health plan, will these individuals continue with their existing health plan through December 31, 2017?	Individuals in the CCC program will continue to receive services as they currently do until they become enrolled in CCC Plus. CMHRS services, including Mental Health Case Management, will be covered by Magellan through 12/31/2017.
Is this webinar being recorded for later viewing?	It is not. The presentation is posted on the website. Questions will be posted in an FAQ document on the DMAS website, which will be updated regularly.

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Questions and Answers (Edited for clarity)

Question	Answer
Is the ability to change plans until the 18th of the following month a change? I thought it was 90 days to change initially?	Individuals will receive a letter which will tell them their enrollment date by the 18th of the current month. As long as they call by the deadline date listed in their letter, they can change their health plan. New members always get 90 days to select a health plan.
Is the letter to be sent to members and the health plan comparison chart available on the DMAS website?	The link to the information is posted on the Maximus website. If you go to the CCC Plus helpline website – cccplusva.com - materials are posted there.
What about transportation services?	Both emergency and non-emergency transportation are covered under the health plan with one exception - the three DMAS DD Waivers. Transportation under the waivers is covered under fee for service.
Will providers need to be credentialed with each of the 6 providers?	Yes, providers should contact each CCC Plus health plan and work with their network departments to become credentialed and contracted.
Has the prior authorization (PA) registration process been streamlined with all health plans? Will CMHRS providers need to obtain PA's through each health plan?	DMAS is working with the health plans to streamline the service authorization and registration process as much as possible. Once CMHRS transitions to the health plans on 1/1/18, CMHRS providers will need to obtain authorizations through the member's selected health plan.
How do we get the health plans to begin a negotiation process with us? They are telling us via email that they do not negotiate with the rates.	Providers should refer to the contact list for the health plans on the website. Providers may want to call and negotiate instead of communicating by email. If providers have tried direct communication and continue to have difficulty, providers should inform DMAS through the DMAS CCC Plus email address.
Effective January 1, 2018, would members need to get an authorization through the new CCC plus provider effective January 1, 2018 or would the member's current authorization still be valid until the end date and then do we request the authorization through the new provider?	The authorization through Magellan will be honored if it goes beyond 1/1/2018. The authorization will end by the established authorization end date or at the end of the 90 day continuity of care period, whichever comes first.
Are we able to see the selected health plans for our clients if we check the Medicaid portal?	Yes

CCC Plus Provider Webinars
Questions and Answers (Edited for clarity)

Question	Answer
When should members who are receiving CMHRS services receive notices about the change in health plans?	CMHRS will transition from Magellan to the health plans on 1/1/2018. This change in who administers the CMHRS programs does not impact the member's health plan assignments.
For CMHRS services that currently require a "registration" through Magellan, will they require an actual prior authorization through the new health plans?	DMAS will be working with providers in September/October regarding the transition of CMHRS from Magellan to the health plans. DMAS is working with the health plans to streamline processes as best as possible.
Regarding pre-op forms/provider specific intakes paperwork, will the health plans use the same form or how will DMAS determine processes for 6 different entities?	DMAS will be implementing a workgroup to determine which processes can be streamlined as much as possible. The workgroup will include representation from various provider groups, DMAS and the health plans. DMAS will develop a reference document for providers to compare the processes between the health plans. The anticipated date of the workgroup is September/October 2017.

Home health/Personal Care/PDN/respite/hospice provider webinar

Question	Answer
Will these provider webinars get into specifics for each provider?	These webinars are not provider specific. The town hall meetings will get into more specifics. In addition, individual health plans are also providing provider trainings.
How is EPSDT going to be handled for carved out services?	For carved out services, they will be handled as they are today. For non-waiver services, the health plans will be covering these services (such as their medical care).
Will the providers each have their own standards for prior approval of DME or will all health plans have the same requirements?	The health plans are required to use criteria like Medicaid criteria. It cannot be stricter than Medicaid criteria per the contract between DMAS and the health plans. A copy of the contract is available on the CCC Plus website.

CCC Plus Provider Webinars
Questions and Answers (Edited for clarity)

Question	Answer
If an authorization is received for one health plan but the member moves to another health plan, who covers the service? The health plan that approved the authorization or the health plan at the date of service?	Authorizations will be honored by the health plan the member moves to. Whoever the member is enrolled with on the date of service will pay for the services with the exception of hospital services. If there is a DRG payment, the plan that initiated the approval will pay the entire DRG. If not a DRG payment, the authorizations will be transferred from one plan to another and the payments will be split by dates of service.
Will the member be able to change plans monthly or will they be enrolled for a year?	Individuals cannot change monthly. The individual can change plans during the initial assignment period and 90 days after the date of enrollment. The member could change plans 6 times within that period of time but once they go back to a plan they started with they can no longer change. After this period is over there will be an annual open enrollment period starting in 2018 that corresponds with Medicare and takes place October-December.
How long will a current authorization from Medicaid be valid after the rollout? Will it be honored for 90 days?	An authorization for an individual under fee for service (FFS) is honored up to 90 days from the effective date of enrollment or until the end of the existing service authorization, whichever comes first.
When will our client be notified of what plan that they are enrolled in?	Letters with assignments will be mailed to the members around the 19th of each month. Enrollment is effective the first of the next month following assignment, which is usually around 40-45 days later.
Am I correct in that each person's letter will have them assigned to a health plan but the letter will also list other options?	The letter gives the member an initial assignment but it also tells them that they can change plans and provides information on how to contact Maximus to make that change. They can also look on the CCC Plus website to see which providers participate in which plans' network. The website is cccplusva.com.

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Question	Answer
It sounds like the plan is to ensure that each member has their insurance information prior to the effective date. Is that correct or is it possible that not all members will have their card information prior to the start date?	It is a requirement that the health plans get ID cards to members prior to the first day of enrollment. If the individual called and changed plans after the call by date then it is possible they wouldn't have their card yet.
Will the HCC in the TW program still be responsible for the initial authorization? Will subsequent authorizations come from one of the health plans?	No. DMAS will no longer be responsible for the Tech Waiver program. As each region rolls out the health plans will be responsible for this. DMAS will be responsible until then. As the member rolls in, the plans become responsible.
If the client has QMB coverage and is excluded from CCC Plus, will they still have coverage from DMAS?	They will have whatever coverage they currently have. They will not be impacted by CCC Plus.

DD Provider Webinar

Question	Answer
How will the new health plans relate to existing service facilitators?	If the individual is in the DD waiver, that service is carved out. But more resources will be available than before. There will be more coordination for acute and primary care.
Can you go into more detail as how Early Intervention (EI) service roll in to CCC plus. Will they roll in right away and could there potentially be some children who don't roll in because their Medicaid is under FAMIS?	If they are currently in EI through Medicaid, and receive services through a home and community based waiver, they will transition into CCC Plus by region, beginning August 1 in Tidewater. Blind or disabled children who receive EI services, and who are not in a home and community based waiver will transition into CCC Plus in January 2018. Children who have FAMIS will not transition to CCC Plus.

CCC Plus Provider Webinars
Questions and Answers (Edited for clarity)

Question	Answer
Isn't it true that most EI kids who have Medicaid due to financial eligibility will roll into managed care under Medallion 4? The children rolling in now through December are those who have Medicaid and a waiver. And, those rolling in in January are those with Medicaid under the ABD eligibility category?	Yes, that is correct. CCC Plus includes Medicaid children who receive services through one of the DMAS home and community based services waivers and children who are blind or disabled. EI services for children who are in FAMIS and for non-disabled children in Medallion 3.0 will be included in managed care under Medallion 4.0.
It has been our understanding that the universe of children rolling in under CCC Plus is small compared to our larger Medicaid population.	Yes, that is correct.
Will EDCD families continue with the same number of attendant and respite hours? How will the health plans affect those hours, or will they?	EDCD and Tech Waivers change to the CCC Plus Waiver effective July 1, 2017. The health plans have to cover the same limits and hours as fee-for-service. The hours and limits will not change. There is a 90 day continuity of care period where the health plan will continue services as presently authorized for 90 days or until the end of the authorization, whichever comes first. Before the end of the continuity of care period, the health plan will do an assessment to see if the hours should be increased or decreased. The appeals process applies for any adverse benefit decisions.
Would you give some examples of other services that the individual might receive?	Each health plan offers enhanced benefits that may be different or similar to the other plans. These can be found on the comparison chart on the CCC Plus website. Preventive adult dental care (exams and cleanings) is an example of an enhanced service that all plans will offer.
How can a family determine which is the best health plan for durable medical equipment, or for example feeding formula for g-tube patients...do they need to call each plan?	They can either visit CCCPlusva.com or call the CCC Plus Helpline (Maximus) and talk with them to see which health plan is contracted with the member's provider.
Will prior approval be required in order to schedule doctor appointments? Will they have to go through the Care Coordinator?	Some of the plans require authorization for certain visits but it is not required for a PCP. The care coordinator can help the member to ensure they see their physician timely. Plans will also authorize standing referrals for members who see specialists routinely.

CCC Plus Provider Webinars
Questions and Answers (Edited for clarity)

Question	Answer
Are there any future webinars like this geared toward individuals/guardians?	Starting Tuesday, July 11, weekly calls will be held for members and their families from 12:00 - 12:30. The call in information is available on the DMAS website.
Who does the support coordinator refer families to be screened for the new CCC Plus services? Will DSS still be involved in any way?	DSS and VDH will be doing the screenings for Waivers. If the individual is in CCC Plus they should contact their care coordinator to arrange the screening.

Service Facilitator provider webinar

Question	Answer
Will CCC participants transition to CCC Plus with their current provider? What about individuals with Humana?	Participants in CCC who are enrolled in Virginia Premier or Anthem will automatically be assigned to those health plans. The participants in Humana will be assigned by the same process as all other individuals.
How is the transition of authorizations going to happen between Kepro and the CCC provider? Do we make a new request when the 90 days is up?	Prior to the effective date, each health plan will receive a file with all service authorizations for their individuals and they will generate authorizations for the care coordinators. The authorizations can last up to 90 days or until the end date, whichever comes first. Care coordinators can work with the members to extend authorizations when appropriate.
When and how will the Service Facilitator be given notice as to which provider the client has chosen?	Monthly eligibility checks will clearly identify individuals enrolled and which health plan they are with. This will be available after the 20th of each month.
If I lose Medicaid eligibility or there is a lapse in Medicaid how do I get it back and when I do, how do I get back into an MCO health plan?	If there is a lapse in Medicaid eligibility you will be dis-enrolled from Medicaid and CCC Plus. Monthly checks will pick you back up into CCC Plus for a future date, and you will most likely be enrolled in the same plan as before. Individuals will be covered through fee-for-service until reenrolled into CCC Plus. Individuals will not be retroactively enrolled into a CCC Plus health plan.
Will public partnerships (PPL) continue to be the fiscal agent?	PPL will continue to be the fiscal agent. Nothing will change with PPL.

CCC Plus Provider Webinars
Questions and Answers (Edited for clarity)

Question	Answer
For the CCC Plus Waiver, how much respite will be allowed since EDCD has 480 and Tech has 360?	Starting July 1, 2017, those individuals in the tech waiver will have service authorizations moved to 480, for existing authorizations.
We will be submitting our authorization request for Consumer Direction (CD), Personal Care Attendant (PCA) and Respite hours to each of the health plans. When they authorize the hours, are they sending that authorization to PPL? Or do we have to also do a Kepro authorization request?	The health plan will automatically send service authorizations to PPL. Once in CCC Plus, you will not send any service authorizations to Kepro (unless the individual is in fee-for-service.)
If someone is not in HIPP and then enrolls in CCC Plus, are they able later to enroll in HIPP or are they excluded permanently from that program?	They are not excluded from HIPP.
When the EDCD and Tech waivers combine, will individuals be eligible for more than the Medicaid level of nursing hours (currently it is 16 hrs/day max)?	Existing rules and regulations will still apply.
On the CCC Plus waiver, will individuals who were on the EDCD waiver be able to access Assistive Technology and Environmental Modifications?	Yes, Assistive Technology and Environmental Modifications are included in the new CCC Plus waiver. A Medicaid Memo with additional information will be issued soon.
Are HIPP 4 Kids excluded from CCC Plus?	Any individual who has HIPP is excluded from CCC Plus.
Who do we call if prescription drugs are not covered?	All of the health plans are using a common formulary. If the individual has Medicare they need to call their part D coverage. If they have CCC Plus, they can contact their health plan or Care Coordinator.
Magellan has been the provider for behavioral services. Will they continue in this role? Will the other plans manage and cover these services like Applied Behavioral Analysis (ABA)?	The Magellan health plan participating in CCC Plus is different than the Behavioral Health Services administrator. Services under the administrator will continue until December 31, 2017. Starting January 2018, the health plan will be responsible for Community Health Rehabilitation Services (CHRS).
How is this change going to affect the audit process for Service Facilitators?	Audit for members is going to be performed through the health plan.

CCC Plus Provider Webinars
Questions and Answers (Edited for clarity)

Question	Answer
Will these newly approved/enrolled individuals have the 30 days to switch plans even though it will not be during the open enrollment period?	Yes. For new Medicaid members they have 90 days to switch to another health plan even if it is not open enrollment.
Do you foresee a point at which the Care Coordinator will replace the Service Facilitator?	No.
Plans and revisions have been the role of Service Facilitators. Would you clarify the roles of care coordinators versus Service Facilitators?	DMAS is working to make a chart to clarify the roles of each. Service facilitators should work collaboratively with the Member's Care Coordinator to mitigate any duplication and to ensure that the member receives the care and services that they need in a timely manner.